IMedReviews
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Notice of Independent Review Decision

DATE OF REVIEW: **10/21/2015**

IRO CASE #

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

MS Contin 15 mg # 90, Trazodone 50 mg # 60.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

D.O. Board Certified in Anesthesiology and Pain Management**.**

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

☐ Upheld (Agree)

☐ Overturned (Disagree)

☒ Partially Overturned (Agree in part/Disagree in part)

PATIENT CLINICAL HISTORY [SUMMARY]

The patient is a male who sustained a work related injury. Subsequently patient had multiple back surgeries, spinal cord stimulator times two with very limited success. Patient continues to complain of low back pain exhibited with both axial and radicular pain. Patient has tried multiple medications to include but not limited anti-inflammatory, muscle relaxants, and short acting narcotics with little success. Patient was eventually put on long acting narcotics with moderate success. Currently patient's VAS score is ranging from 5/10 to 6/10.

ANALYSIS FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION AND EXPLANATION OF THE DECISION. INCLUDE CLINICAL BASIS,

Per ODG references the requested "MS Contin 15 mg # 90" is medically necessary, "Trazodone 50 mg # 60" is not medically necessary.
The use of MS Contin 15 mg three times a day is certifiable and medically necessary for this patient. Patient has chronic back pain with a history of post laminectomy syndrome, and spinal cord stimulator times two with very little relief. Patient failed a trial of short term narcotics. The use of long acting narcotics for this patient is medically necessary.
Trazodone 50 mg is not certifiable. Trazodone is recommended for use as a sleep aid with the context of mild coexisting psychiatric symptoms such as depression, and anxiety, which is not well supported by the available documentation provided.

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A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- ☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- ☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- ☐ INTERQUAL CRITERIA
- ☐ MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- ☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- ☐ MILLIMAN CARE GUIDELINES
- ☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- ☐ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- ☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- ☐ TEXAS TACADA GUIDELINES
- ☐ TMF SCREENING CRITERIA MANUAL
- ☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- ☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES